Bidders' Questions # 3

1. On page 24, question #7(Other) it indicates that DSHS can provide the cost information submitted to CMS. When may we expect to get that information? *Cost information submitted to CMS for the previous program accompanies this set of Q & A.*

2. How will the methodology described on page 16 of the original bidder questions and answers be implemented for this type of population? It seems that the approach outlined to measure program cost effectiveness could be affected by response/non-response selection bias. How does the State plan to address this? *Selection bias is always a potential risk in evaluating the impact of service interventions in a non-experimental setting. The outlined approach reduces the potential impact of selection bias in two important ways. First, it essentially eliminates observable differences in the characteristics of intervention clients and comparison clients through the propensity score sampling process. Second, if selection bias takes the form of a "fixed effect" difference in outcome measures between intervention and comparison group members, the bias will be "differenced out" through the use of the "difference-in-differences" approach.*

3. Please elaborate on how cost effectiveness will be determined. *The basic descriptions of the cost and program evaluations are described in the RFP and first set of questions. We anticipate working with the SCM and LCM contractors to finalize what the evaluations will look like.*

4. Scope of the HCS waiver services – are all Aging and Disability Service Administration (ADSA) clients excluded? *Yes, this includes all ADSA clients managed under Home and Community Services waivers and those receiving Medicaid Personal Care (MPC) services. Please see the following questions and answers.*

5. Would this (above) include all clients being managed by the AAA's? *Yes, if their services are paid for by DSHS.*

6. Please clarify the exclusion of "clients receiving home and community based long term care services case managed by ADSA." Information provided to date is somewhat contradictory. The DSHS reply to Bidder's question #64 lists services managed under major ADSA programs (excluding Developmental Disabilities). However, at the bidder's conference DSHS representatives characterized the exclusions as a relatively small number of clients participating in an ADSA case management demonstration. Can you provide a more concrete

description of the excluded population and the number of individuals state-wide? Are developmentally disabled clients "in or out" of the proposed project? *The clients excluded from the Chronic Care Management Project (CCMP) include the MPC and COPES clients case managed by ADSA; AAA and HCS. The number of clients' case managed by HCS/AAA staff (both Medicaid-only and Medicare-Medicaid duals) is around 40,000 (plus or minus a few thousand). In 2001, approximately 15% of Medicaid-only and 40% of dual eligible (Medicare-Medicaid) clients used ADSA services.*

7. Would this (above) include all clients being managed by the AAA's? *This includes clients' case managed by an Area Agency on Aging for MPC or HCS waiver services.*

8. What about DDD aspect of ADSA? Includes clients in ICF/MRs? *Clients to be excluded from the program would be clients in ICF/MRs and those clients being managed under one of the community services waivers, if adding Chronic Care Management program services would duplicate currently provided case management services.*

9. When an enrollee becomes eligible for LTC, will that enrollee then be ineligible for the Chronic Care Management Project? *It would seem a logical time for the SCM/LCM to provide coordination of care with the ADSA case manager for integration of the LTC services into the care plan developed by the SCM/LCM and a hand over to the ADSA case manager. There are Nursing Services resources available to all HCS/AAA/DDD clients for assessment and service planning related to health care needs of the client and/or caregiver.*

10. As part of the criteria to determining cost effectiveness, will a minimum plan participation (for the enrollee) timeframe be utilized? *Overall cost effectiveness would need to include all clients and all costs paid through the program.*

11. From the date of service, what are the state's current claims processing turnaround times to payment for the following claim types: hospital inpatient, emergency department, PCPs specialists and pharmacy. *Providers have 365 days in which to submit claims to Medical Assistance (MA) for processing – MA meets federal requirements for processing clean claims. However, a large number of claims are submitted within the first 30 days after services are provided. See table on next page for average submission and payment times.*

Service type	Average days from service delivery to receipt of claim	Average days from claim entry to payment
Drugs	3.9	8.2
Physician	17.1	10.7
Outpatient	44	11.2
Med vendor	42.6	14.2
DRG inpatient	60.5	13.3
Inpatient, non-DRG	59.6	16.4

12. If the SCM will be responsible for monthly verification of enrollment and disenrollment for all members each month, is it the expectation of the State that the SCM may bill a Basic pmpm which includes all members processed each month irrespective of LCM enrollment? *Yes, the Basic rate is for the predictive modeling component of the SCM. The rate should cover predictive modeling and related services for all approximately 60,000 clients, although it will only be paid as a per member per month amount for clients eligible for the SCM outside the LCM areas.*

13. Please clarify the number of project enrollees for whom the SCM vendor will be performing care management services. This is necessary so that all offerors are bidding their services on the same number of participating high cost enrollees for SCM evaluation purposes. *We do not agree that this is necessary for your bid. DSHS would like bidders to determine the number of clients that you believe will be identified as appropriate for care management, who are able to be contacted, and who agree to participate in the program. Your bid should include the number of active participants you expect to manage, and a per member per month rate to provide necessary services.*

14. "The historical prescription drug costs for Dual Eligible clients will be dramatically reduced due to Medicare Part D coverage." We have two questions related to this statement:

    a. Data provided with the RFP comes from before the implementation of Medicare Part D. Most of all Dual Eligible clients will qualify for Low Income Subsidy (LIS) provisions of Part D, but some Medicaid costs will remain, especially for those Dual Eligible clients who qualify for only partial subsidy. Can you provide an estimate of the adjusted prescription drug costs PMPM with Part D in place? *Here is an example from the rates build up for a managed care plan that includes dual eligibles. For clients in nursing homes, the average expenditures on drug claims were $352 per month, those who did not use long term care services spent on average $200 per month.*

After Part D began, the rate paid for Rx dropped to $16 for nursing home clients and $10 for clients who are not in long term care.

b. Information available to us from CMS suggests that large numbers of people for Part D with LIS have not yet enrolled. Can bids include efforts to enroll Medicaid CCM-eligible individuals in Part D? And if so, can savings to the state due to reduce Medicaid outlay (distinct from prescription drug outlay) be counted as part of the savings that achieve cost neutrality in the program evaluation? We believe this provides an example of the kind of broad-context case management needed at the local level and the scope of savings that should be "scored".

   If the client eligibility files show the client is dual eligible, the prescription drug claims will deny in the Point of Sale system to bill Medicare, even if the client is not currently on a Part D plan. So there are no savings to be achieved. Since dual eligibles are required to participate in Part D, it is unlikely the Contractor would sign many clients up for the program, but might assist an Enrollees in changing their Part D plan.

15. Can you confirm that DSHS does not want to include anyone under 18 in the program? *This assumption is correct. The program will not include clients under 18.*

16. As we were doing a review of the PAHP contract, we were wondering what the approved languages for enrollment notices, informational materials, and instructional materials would be. *The top seven languages that DSHS translates materials into are: Spanish, Russian, Chinese, Vietnamese, Cambodian, Laotian and Korean. Spanish and Russian are the top two and we would probably start with translations into those two languages, then increase the translations as necessary.*

17. Section E. 11. for the RFP states: "For SCM bidders, provide documentation of certification or accreditation from any national accreditation bodies." Our question is: Would the State accept a team bid that did not have accreditation at the time of submission, but is applying to NCQA and expects to be accredited?
   We would accept documentation of the application to NCQA and your reasoning for thinking you will be accredited. You can also answer the second part of the question, which is: "Also provide at least three examples of areas of need for improvement from the most recent accreditation site visit, and how you have addressed them."

Clarification of previous question from first set of Q & A:

Page 27, question 31: Will DSHS use an outside consultant or other entity to evaluate the RFP responses, and if so, tell us who that is? *While our team of evaluators is made up of state staff, at least one member is from outside DSHS. In addition, we are planning to take advantage of expertise offered through the Agency for Healthcare Research and Quality Learning Network, which includes consultants from Lewin and the Center for Healthcare Strategies. If needed, we may also call upon our contracted actuaries at Milliman for consultation on Predictive Modeling and cost-effectiveness.*